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Introduction

Consumer Directed Option (CDO) allows persons eligible for services through one of the 1915c waiver programs -- Acquired Brain Injury (ABI), Acquired Brain Injury Long-Term (ABI-LTC), Home and Community Based (HCB), Michelle P (MP), and Supports for Community Living (SCL) -- to choose their own providers for **non-medical, non-residential** waiver services. CDO gives members flexibility in the delivery and type of services they receive by placing them in charge of directing services and managing a monthly budget based on their authorized service care needs. CDO also allows consumers to use a portion of their flexible allowances to purchase goods and services that are necessary to help them continue to live independently in their home and community. CDO differs from traditional waiver approaches in that the consumer is in charge of determining available services, scheduling, employing, budgeting, and evaluating the usefulness of the services, rather than a traditional waiver case manager. CDO is not for everyone, because not everyone is willing or able to manage all of the requirements or otherwise have a trusted representative to manage all of the tasks for them. The goal of the CDO model is to offer consumers the ability to direct services that most appropriately meet their needs, using person-centered planning principles, in order to remain living in the community. The following CDO and person-centered planning principles are essential to the CDO model:

- (1) Reflects the belief that individuals, when given the opportunity to choose the service(s) they will receive and direct some or all of them, will exercise their choice in ways that maximize their quality of life;
- (2) Includes person-centered planning principles to ensure that the consumer is making personal choices for the spending of the budget based on his or her own needs and goals;
- (3) Provides one option among several service delivery models, and it must be available for all consumers who choose the option;
- (4) Requires a flexible, individualized budget that the consumer may spend on services that assist him or her to meet their community support needs and enhance their ability to live in the community by -
 - a. Allowing the consumer to use their individualized budget to choose and directly hire workers to provide the services;
 - b. Allowing the consumer to use their individualized budget to purchase goods, supplies, or other items to meet community support needs; and
 - c. Providing the consumer with a significant choice in the allocation of their funds between hiring providers and making other purchases.

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- (5) Allows the consumer to designate a representative to help him or her with making decisions and managing their services;
- (6) Provides a system of supports to assist the consumer in developing and managing his or her spending plan, fulfill the responsibilities of an employer, including managing payroll for workers he or she hires directly, and obtain and pay for other services and goods; and
- (7) Obtains feedback from consumers, representatives, and family members (when appropriate), as well as data from support service providers to continuously improve the program.

CDO is a Medicaid funded program; therefore, adherence to both federal and state program rules is required.

The regulatory language associated with the facilitation of CDO services for each waiver may be found in the following Kentucky Administrative Regulations (KAR):

- 907 KAR 1:145 Supports for Community Living Services for an Individual with Mental Retardation or a Developmental Disability;
- 907 KAR 1:155 Payments for Supports for Community Living Services for an Individual with Mental Retardation or a Developmental Disability;
- 907 KAR 1:160 Home and Community Based Waiver Services;
- 907 KAR 1:170 Reimbursement for Home and Community Based Waiver Services;
- 907 KAR 1:835 Michelle P Waiver Services and Reimbursement;
- 907 KAR 3:090 Acquired Brain Injury Waiver Services;
- 907 KAR 3:100 Reimbursement for Acquired Brain Injury Waiver Services;
- 907 KAR 3:210 Acquired Brain Injury Long-Term Care Waiver Services and Reimbursement

In order to ensure that the most current version of the regulation is being followed, it is imperative that support brokerage and financial management staff check the following Kentucky Legislative Research Commission (LRC) website at <http://www.lrc.ky.gov/kar/TITLE907.HTM> and follow the current regulation language for each waiver.

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Medicaid Financial Eligibility

Financial eligibility criteria require all participants who wish to participate in CDO to first meet the income requirements for one of Kentucky's participating 1915c Medicaid waiver programs (ABI, ABI-LTC, HCB, MP, or SCL). Before enrolling in CDO, the appropriate Medicaid eligibility shall be determined by the local Department for Community Based Services (DCBS) Family Support office and the applicant shall be enrolled in a Medicaid Waiver Program. Medicaid coverage must be secured and verified for the purposes of guaranteeing ongoing payment, goods and supports to effectively serve participants safely in their communities.

The DCBS Family Support Office is responsible for the annual financial determination of all waiver populations. To locate a participant's local DCBS office, visit DCBS's website at the following link: <http://www.chfs.ky.gov/dcbs>. Click the top right hand bullet 'Find Your Local DCBS Office' to find an office in your area. Financial resources must be within Medicaid resource guidelines. The resource limits vary accordingly when the potential participant is married, as the spouse's resources are also considered. Below are financial resource limits according to marital status and service options as identified on the MAP 418 Medicaid Waiver Services Fact Sheet, revised July 2009:

Marital Status	Services Being Received	Resource Limit
Single Person	Medicaid Waiver services	\$2,000.00
Married Couple	Both get Medicaid Waiver services	\$4,000.00
Married Couple	One spouse gets Medicaid Waiver services and the other does not	\$23,912.00 or spousal share (maximum \$109,560.00) + \$2,000.00

The support broker shall initially verify on a monthly basis the participant's Medicaid eligibility. In order to qualify for waiver services, including CDO, the participant cannot be receiving *Qualified Medicare Beneficiary (QMB)* and / or *Passport Health Plan* benefits. The DCBS office can help confirm the type of eligibility, if the Support Broker is unable to determine eligibility via the Kentucky Health Network system. The participant may call the local DCBS office to obtain further instructions or information on what is required to complete the application process to determine Medicaid financial eligibility for waiver services.

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Medicaid Waiver Eligibility

In addition to Medicaid financial eligibility, participants who choose CDO must meet the respective waiver program criteria as outlined in the appropriate administrative regulation. Program eligibility must be secured and verified for the purposes of guaranteeing ongoing payment and supports to serve participants in their home and community as individual functional needs may change thereby affecting their program eligibility.

QIO determines LOC in accordance with 907 KAR 1:022. To be eligible to receive services outlined in the waivers below, the individual must meet the following program criteria:

(1) Acquired Brain Injury (ABI) waiver:

- (a) Be at least 18 years of age;
- (b) Have a primary diagnosis of an acquired brain injury of the following nature, to the central nervous system: injury from physical trauma, damage from anoxia or from a hypoxic episode or damage from an allergic condition, toxic substance or another acute medical incident and that indicates an ABI with structural, non-degenerative brain injury;
- (c) Apply to be placed on the ABI Waiting List (if applicable) in accordance with 907 KAR 3:090 Section 7;
- (d) Meet patient status criteria for nursing facility services including nursing facility services for a brain injury as established in 907 KAR 1:022;
- (e) Be medically stable;
- (f) Meet Medicaid eligibility requirements established in 907 KAR 1:605;
- (g) Exhibit cognitive, behavioral, motor or sensory damage with a potential for rehabilitation and retraining;
- (h) Have a rating of a least four (4) on the Family Guide to the Rancho Levels of Cognitive Functioning (Rancho Los Amigos Scale);

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- (i) Receive notification of approval from the department; and
- (j) Shall not remain in the ABI waiver program for an indefinite period of time.

To maintain eligibility as an ABI recipient, the individual must meet the following program criteria:

- (a) Meet Medicaid eligibility requirements established in 907 KAR 1:605;
- (b) Be reevaluated at least every 12 months to determine if individual meets patient status criteria for nursing facility services as established in 907 KAR 1:022;
- (c) If ABI recipient is admitted to ABI waiver program, discharged from the ABI waiver program, temporarily discharged from ABI waiver program, readmitted from a temporary discharge, admitted to a nursing facility, changing the primary provider or changing case management/support brokerage agencies, the support broker must notify the local DCBS office, Acquired Brain Injury Branch, and the department through a MAP 24C form, (Admittance, Discharge or Transfer of individual in the ABI/SCL Program); and
- (d) Be expected not to exceed the cost of nursing facility services through the projected cost of ABI waiver services.

(2) Acquired Brain Injury Long Term Care (ABI-LTC) waiver:

- (a) Be at least 18 years of age;
- (b) Have an ABI which necessitates supervision, rehabilitative services and long term supports;
- (c) Have an ABI that involves cognition, behavior or physical function;
- (d) Be enrolled on a first priority basis if the individual is currently being served on the ABI waiver and has reached maximum rehabilitation potential or has previously received ABI waiver services and is currently in a nursing facility or ICF/MR/DD and meets eligibility criteria;

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- (e) After all first priority basis individuals have been enrolled, the remaining ABI rehabilitation waiver waiting list individuals who meet eligibility will be enrolled through the department;
- (f) After all individuals have been enrolled, the department will utilize a first come, first serve priority basis to enroll an individual who meet eligibility;
- (g) Be placed on the ABI Long-Term Care waiting list if funding is not available;
- (h) Support broker, on behalf of the applicant, shall submit a certification packet to the department which will include the following:
 - (1) A copy of the allocation letter sent to the applicant at the time funding was allocated for the applicant's participation in the ABI Long-Term Care waiver program;
 - (2) A MAP 351 form (Assessment);
 - (3) A statement of the need for ABI Long-Term Care waiver services, which shall be signed and dated by a physician on a MAP 10 form (Waiver Services Physician's Recommendation);
 - (4) A MAP 350 form (Long Term Care Facilities and Home and Community Based Program Certification);
 - (5) A MAP 109 form (Plan of Care); and
 - (6) The ABI recipient's MAP 24C form (Admittance, Discharge or Transfer of an Individual in the ABI/SCL Program).
- (i) Meet patient status criteria for nursing facility, including nursing facility services for a brain injury established in 907 KAR 1:022;
- (j) Have a primary diagnosis that indicated an ABI with structural, non-degenerative brain injury;
- (k) Be medically stable;
- (l) Meet Medicaid eligibility requirements established in 907 KAR 1:605;
- (m) Exhibit cognitive damage, behavioral damage, motor damage, or sensory damage;

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- (n) Have a rating of at least four (4) on the Rancho Levels of Cognitive Functioning, The Revised Levels – Third Edition;
- (o) Receive notification of approval from the department; and
- (p) Be expected not to exceed the cost of nursing facility services through the projected cost of ABI waiver services.

(3) Home and Community Based waiver:

- (a) Meet Medicaid eligibility requirements;
- (b) Meet nursing facility level of care as established in 907 KAR 1:022;
- (c) Would, without waiver services, be admitted by a physicians' order to a nursing facility;
- (d) Be evaluated at least every 12 months for nursing facility level of care determination;
- (e) Require a service other than case management and/or a minor home adaptation;
- (f) Is not an inpatient of a hospital, nursing facility, or an intermediate care facility for an individual with mental retardation or a developmental disability;
- (g) Is not a resident of a licensed personal care home;
- (h) Is not receiving services from another Medicaid Home and Community Based services waiver program;
- (i) Per support broker, require recipient to sign a MAP 350 form (Long Term Care Facilities and Home and Community Based Program Certification), as documentation that recipient chose to remain at home and receive waiver services as opposed to be institutionalized; and
- (j) Be expected not to exceed the cost of nursing facility services through the projected cost of HCB waiver services.

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(4) Michelle P (MP) waiver:

(a) Meet MP waiver service level of care criteria as outlined below:

- (1) Requires physical or environmental management or rehabilitation and
 - i. Has a developmental disability or significantly sub-average intellectual function;
 - ii. Requires a protected environment while overcoming the effects of a developmental disability or sub-average intellectual functioning while learning fundamental living skills, obtaining educational experiences which will be useful in self-supporting activities, or increasing awareness of his or her environment; and/or
 - iii. Has a primary psychiatric diagnosis if possessing care needs listed in subparagraph i and ii of this paragraph, the individual's mental care needs are adequately handled in an ICF-MR-DD and the individual does not require psychiatric inpatient treatment.
- (2) Has a developmental disability and meets the high-intensity nursing care patient status criteria as established in 907 KAR 1:022 Section 4(2) or low-intensity nursing care patient status criteria as established in 907 KAR 1:022 Section 4(3).

(b) Meet Medicaid financial eligibility requirements;

(c) Would, without waiver services, be admitted to an ICF-MR-DD or a nursing facility;

(d) Be reevaluated at least every 12 months to determine if individual meets patient status criteria for nursing facility services as established in 907 KAR 1:022;

(e) Require a planned program of active treatment to attain or maintain an optimal level of functioning;

(f) Require a service other than case management, environmental and minor home adaptation;

(g) Is not an inpatient of a hospital, nursing facility or ICF-MR-DD;

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- (h) Is not a resident of a licensed personal care home;
- (i) Is not receiving services from another Medicaid Home and Community Based waiver program; and
- (j) Chooses to remain at home and receive waiver services as opposed to be institutionalized.

(5) Supports for Community Living (SCL) waiver:

- (a) Be placed on the SCL waiting list in accordance with 907 KAR 1:145 Section 7;
- (b) Receive notification of potential SCL funding in accordance with 907 KAR 1:145 Section 7;
- (c) Meet ICF-MR-DD patient status requirements as established in 907 KAR 1:022;
- (d) Meet Medicaid eligibility requirements as established in 907 KAR 1:605;
- (e) Submit an application packet to the department which shall contain the following:
 - (1) MAP 350 form (Long Term Care Facilities and Home and Community Based Program Certification);
 - (2) MAP 351 form (Assessment);
 - (3) Results of a physical examination that was conducted within the last 12 months;
 - (4) MAP 10 statement of need for long-term care services which shall be signed and dated by a physician or an SCL MRP and be less than one (1) year old;
 - (5) Results of a psychological examination completed by a licensed psychologist or psychologist with autonomous functioning;
 - (6) Social case history which is less than one (1) year old;
 - (7) Projection of the needed supports and a preliminary MAP 109 form (Plan of Care) for meeting those needs;
 - (8) MAP 24C documenting individual's status change; and

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(9) Copy of the letter notifying the SCL recipient of an SCL funding allocation.

- (k) Receive notification of an admission packet approval from the department; and
- (l) Is not receiving services from another Medicaid waiver program or is an inpatient of an ICF-MR-DD or other facility.

To maintain eligibility as an SCL recipient, the individual must meet the following program criteria:

- (a) Must have NC-SNAP assessment administered by the department in accordance with 907 KAR 1:155;
- (b) Must maintain Medicaid eligibility requirements as established in 907 KAR 1:605;
- (c) ICF-MR-DD level of care determination must be performed by the department at least every 12 months;
- (d) Is not receiving a service in another Medicaid waiver program or is an inpatient of an ICF-MR-DD or other facility; and
- (e) Be expected not to exceed the cost of nursing facility services through the projected cost of SCL waiver services.

In addition to the criteria outlined in the above waivers, support brokers shall facilitate the completion of the following forms in order for CDO services to initially be rendered to a consumer:

- (1) MAP 10 form (Waiver Services Physician's Recommendation);
 - (a) The MAP-10 details the statement for need of long-term care services and shall be signed and dated by the appropriate licensed provider as outlined below, and be less than one (1) year old:
 - **ABI and ABI-LTC:** Physician
 - **HCB:** Physician, advanced registered nurse practitioner (ARNP) or physician's assistant (PA)

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- **MP:** Physician, PA, ARNP or Qualified Mental Retardation Professional (QMRP)
- **SCL:** Physician or SCL Mental Retardation Professional (MRP)

- (2) MAP 351 form (Medicaid Waiver Assessment);
- (3) MAP 350 form (Long Term Care Facilities and Home and Community Based Program Certification);
- (4) MAP 109 form (Plan of Care/Prior Authorization for Waiver Services);
- (5) MAP 2000 form (Initiation/Termination of CDO);
- (6) MAP 95 form (Request for Equipment), if applicable;
- (7) Rights, Responsibilities, and Risks form;
- (8) IRS 2678 form (Employer/Payer Appointment of Agent) or SS4 form (Application for Employer Identification Number); and
- (9) Adaptation of Quality Life Changes Survey.

CONSUMER DIRECTED OPTION Consumer Self-Direction or Representative Designation and Responsibilities	DAIL-CDO-6.4
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Consumer Self-Direction or Representative Designation and Responsibilities

Individuals who meet eligibility and financial requirements in one of the 1915c waiver programs (ABI, ABI-LTC, HCB, MP, and SCL) and choose to direct their non-medical, non-residential waiver services must have the ability to self-direct their own care and understand the rights, responsibilities, and risks of managing their own care.

Consumers who are unable to make decisions independently may designate a representative to assume their responsibilities or act on behalf of the consumer in order to safeguard the consumer's health, safety and welfare, and avoid institutional placement while living in the community. The consumer, support broker, DAIL, or DMS may request a designated representative to make decisions. Following is a summary that outlines of the rights, responsibilities, and risks of the consumer or representative, if designated.

The consumer/representative has the RIGHT to:

- (1) Choose whether an authorized service will be provided by a traditional waiver provider or through CDO;
- (2) Work with a support broker in developing a plan of care and support spending plan individualized to the consumer's needs;
- (3) Choose who they hire as providers;
- (4) Have a face-to-face visit with a support broker and be informed of the balance remaining in consumer's approved CDO budget; and
- (5) Contact a support broker twenty-four (24) hours per day and seven (7) days per week if a need or question arises.

The consumer/representative has the RESPONSIBILITY to:

- (1) Be trained to coordinate consumer's care and manage their budget prior to beginning CDO services;
- (2) Participate in monthly face-to-face visit with Support Broker;

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- (3) Work with a support broker to determine natural supports (family and friends) who can assist consumer when his/her CDO services are not being provided;
- (4) Hire and train employees who consumer can trust to perform the services outlined in his/her plan of care;
- (5) Work with a support broker to ensure consumer providers are cleared through the criminal background check, Kentucky Nurse Aide Registry, and Central Registry Check (according to the appropriate waiver regulation) prior to starting services;
- (6) Manage employees and ensure timesheets and service notes are documented correctly before being submitted to the support broker;
- (7) Stay within consumer's approved CDO annual budget and service hour and unit limits as outlined in the appropriate KAR;
- (8) Pay consumer's monthly patient liability on time, if applicable; and
- (9) Maintain consumer's eligibility for Medicaid.

The consumer/representative has the RISK of being terminated from Consumer Directed Option:

- (1) If consumer fails to pay their monthly patient liability;
- (2) If consumer does not use their CDO services within sixty (60) consecutive days (excludes MP and HCB);
- (3) If consumer does not make appropriate decisions concerning their CDO services which places their health, safety and welfare in jeopardy;
- (4) If consumer is non-compliant with their plan of care; and
- (5) If consumer over-spends or mismanages their approved CDO budget.

An individual must meet the following criteria in order to be designated as a CDO representative:

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- (1) Be willing to act on behalf of the consumer and understand the rights, responsibilities, roles, and risks of managing the care of the consumer;
- (2) Be at least twenty-one (21) years of age;
- (3) Not be monetarily compensated for serving as the CDO representative ;
- (4) Not provide any CDO service;
- (5) Have no vested interest in any agency that may provide waiver services;
- (6) Agree to a pre-determined frequency of contact with the consumer;
- (7) Be willing to comply with all criteria and responsibilities of the consumer;
- (8) Agree to assist the consumer with managing the benefit total based on the consumer's approved plan of care and support spending plan;
- (9) Obtain approval by the consumer or family to serve in this capacity; and
- (10) Be listed on the MAP 2000 and MAP 109 forms.

A minor who is receiving CDO services should have a designated CDO representative. The minor's legal guardian may act as the representative or another individual may be chosen to act as the representative.

An individual, who has a court-appointed guardian and is receiving CDO services, should have a designated CDO representative. The court-appointed guardian may act as the representative or another individual may be chosen to act as the representative.

If an individual's legal or court-appointed guardian acts as the CDO representative, then he/she must sign all CDO documents, on behalf of the consumer.

A state guardianship worker may serve as a designated representative; however, he/she is not required to serve in this capacity.

A support broker shall not be a provider of services or supports, other than support brokerage services, to any consumer enrolled in CDO. A support broker cannot serve as the consumer's designated representative.

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A financial manager shall not be a provider of services or supports other than financial management services to any consumer enrolled in CDO. A financial manager cannot serve as a consumer's designated representative.

It is the role of the support broker to ensure consumers and representatives, if designated, are informed of and understand the rights, responsibilities, and risks of uncertain outcomes to ensure success of the CDO approach for services.

The CDO Rights, Responsibilities and Risks Statement is a document that shall be reviewed with the consumer and representative at the initiation and annually throughout the duration of CDO services.

The Rights, Responsibilities, and Risks Statement must be signed and dated by the consumer unless a representative has been designated. If a representative has been designated, the representative must sign and date on behalf of the consumer.

The support broker must also sign and date the Rights, Responsibilities, and Risks Statement. A completed copy of this document must be present in the consumer's file located at the AAAIL or CMHC.

CONSUMER DIRECTED OPTION Organizational and Structural Administration	DAIL-CDO-6.5
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Organizational and Structural Administration

The Department for Medicaid Services (DMS) has authorized the Department for Aging and Independent Living (DAIL) to administer CDO. DAIL is responsible for the day-to-day operation of CDO at the state level, while additional roles associated with the model are fulfilled as follows:

- (1) **Area Agency on Aging and Independent Living (AAAIL)** – DAIL contracts with the AAAILs to provide support brokerage services to participants choosing CDO through the ABI, ABI-LTC, HCB, MP, and SCL waiver programs.
- (2) **Area Development District (ADD)** – DAIL contracts with the ADDs to provide the financial management components of the CDO service delivery system.
- (3) **Community Mental Health Center (CHMC)** – DAIL has provider agreements with the CMHCs to provide support brokerage and financial management services to participants choosing CDO through the ABI, ABI-LTC, MP, and SCL waiver programs.
- (4) **Medicaid Agency Provider** – These agencies have permission from Medicaid to provide Medicaid funded services. A list of Medicaid providers specific to the aforementioned waivers include:
 - a. Adult Day Healthcare Centers (ADHC)
 - b. Community Mental Health Centers
 - c. Home Health Agencies
 - d. SCL Traditional Providers
 - e. Area Agencies on Aging and Independent Living (CDO Only)
- (5) **Quality Improvement Organization (QIO)** – Medicaid contracts with a QIO to determine level of care, as well as to approve and prior authorize services requested on the plan of care of the consumer.

CONSUMER DIRECTED OPTION Relationship between Traditional Waiver Services and CDO	DAIL-CDO-6.6
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Relationship between Traditional Waiver Services and CDO

If a waiver participant chooses to have services provided under the traditional option, the case manager is responsible for the development of a plan of care to meet the needs of the individual.

If a waiver participant chooses CDO, the Support Broker is responsible for facilitating the person-centered planning process by developing a plan of care and support spending plan that addresses the consumer's needs. This includes arranging for services from a variety of resources such as state funds, private funds, and natural supports.

A waiver participant may choose to blend services. Blended services are defined as a non-duplicative combination of authorized waiver service(s) that is/are being provided pursuant to a participant's approved plan of care. When a participant chooses to use blended services, he/she receives one or more services from a traditional provider, while directing other services under CDO. If a participant chooses the blended service option, he/she will no longer receive case management services from a traditional waiver provider, as the support broker will be responsible for leading case management and facilitating the person-centered planning process.

A participant cannot receive the same waiver service(s) from both a traditional provider and through CDO.

Following is an example of a non-duplicative blended service:

A participant who has chosen and is approved to receive community living supports (CLS) through a traditional provider cannot also hire a CDO employee to provide community living supports (CLS), even if the service would be provided at different hours on the same day.

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Administrative Responsibilities of the Area Development District (ADD) and the Community Mental Health Center (CMHC)

The ADD and CMHC shall be responsible for planning, organizing, and administering a district-wide service delivery system which complies with statutory and regulatory intent, meets all requirements of the 1915c waiver programs, and is approved by the DAIL.

The following requirements are for administration of CDO:

- (1) Serve all applicants who meet the regulatory requirements for participation in CDO. The support brokerage agency may refuse to provide services to a consumer for reasons specified in 907 KAR and in section 3 V. of the contractual agreement between DAIL and AAAILs;
- (2) Not create a waiting list;
- (3) Provide support brokerage services;
- (4) Provide financial management services;
- (5) Submit requests for budget adjustments (exceptions) to DAIL;
- (6) Maintain incident reports in a centralized file separate from consumer's file; and
- (7) Notify DAIL, verbally and in writing (through an incident report), within one (1) business day of any complaint investigations by Adult Protective Services (APS) or Child Protective Services (CPS).

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The support brokerage agency shall maintain and submit the required reports to DAIL using the secured MOVEit website. Each AAAIL and CMHC has a folder on MOVEit to upload or download data. All data shall be entered into the DAIL approved standardized data spreadsheet. Following are the required reports due to DAIL within the specified timeframe:

- (1) **Consumer Enrollment Report** (per waiver) - shall include at a minimum:
- a. Consumer's first and last name;
 - b. Consumer's Medicaid Assistance Identification (MAID) number;
 - c. Consumer's age;
 - d. Consumer's county of residence;
 - e. Consumer's Medicaid waiver program;
 - f. Support brokerage agency;
 - g. Support broker's name;
 - h. Date of enrollment (date of first home visit);
 - i. Date CDO services initiated (date support broker receives consumer's CDO budget from Medicaid);
 - j. Notification if CDO services were not initiated; and
 - k. Date of termination.

This is a monthly report and is due to DAIL on or before the 15th of each month following the previous month of service.

- (2) **Corrective Action Plan (CAP) Report** – shall include:
- a. Consumer's first and last name;
 - b. Consumer's Medicaid Assistance Identification (MAID) number;
 - c. Consumer's county of residence;
 - d. Consumer's Medicaid waiver program;
 - e. Support brokerage agency;
 - f. Detailed reason for necessity of CAP;
 - g. Consumer's complaint with CAP, if applicable;
 - h. Detailed note of consumer's progress with CAP; and
 - i. Date consumer shall be in compliance with CAP.

This is a quarterly report and is due to DAIL on or before October 15th, January 15th, April 15th, and August 15th of each contract year.

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(3) Support Broker Caseload Report – shall include:

- a. Support broker's name;
- b. Number of cases per support broker, listed by waiver type; and
- c. If applicable, a plan of correction if any support broker caseload(s) exceed 40 consumers for thirty (30) days or more, which shall include:
 - i. Justification for caseload(s) exceeding 40 consumers;
 - ii. How support brokerage agency will reduce caseload(s) to no more than 40 consumers;
 - iii. Timeline for corrective action; and
 - iv. How support brokerage agency will prevent future incidences of caseload(s) exceeding 40 consumers.

This is a monthly report and is due to DAIL on or before the 15th of each month following the previous month of service.

(4) Consumer Satisfaction Survey Report (Adaptation of Quality Life Changes) – shall include:

- a. Consumer's waiver program;
- b. Consumer's county of residence;
- c. Support brokerage agency; and
- d. Responses to each question on the Adaptation of Quality Life Changes, Initial and Follow-up survey tool.

The consumer satisfaction survey report is an annual report and is due to DAIL on or before January 30th of each year. If a consumer refuses to complete the survey, the survey shall still be located in the consumer's file, and a statement of refusal shall be written on the front of the survey by the support broker and include the date, reason for the refusal, and signature of support broker.

CONSUMER DIRECTED OPTION Administrative Responsibilities of the Area Development District (ADD) and Community Mental Health Center (CMHC)	DAIL-CDO-6.7
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Complete and maintain all records and documentation relative to each consumer within their files, including the following at a minimum:

(1) Initially:

- a. MAP 350;
- b. MAP 2000;
- c. Prior Authorization;
- d. MAP 109;
- e. MAP 10;
- f. MAP 351;
- g. MAP 95, if applicable;
- h. Rights, Responsibilities, and Risks Statement;
- i. IRS Form 2678 or SS4; and
- j. Adaptation of Quality Life Changes Survey (consumer's satisfaction survey).

(2) Annually:

- a. MAP 10;
- b. MAP 351;
- c. MAP 350;
- d. MAP 109;
- e. Rights, Responsibilities, and Risks Statement;
- f. Follow-up of Adaptation of Quality Life Changes Survey; and
- g. MAP 552, if applicable.

(3) Monthly:

- a. Consumer eligibility and verification; and
- b. Detailed support broker case note.

CONSUMER DIRECTED OPTION Administrative Responsibilities of the Area Development District (ADD) and Community Mental Health Center (CMHC)	DAIL-CDO-6.7
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(4) When applicable:

- a. Provider Documentation including:
 - i. Employment application;
 - ii. Timesheets with original signatures of support broker, consumer/representative, and employee;
 - iii. Annual contracts;
 - iv. Background checks;
 - v. Training verification;
 - vi. I-9 form; and
 - vii. State and Federal Tax withholdings.
- b. MAP 24(C);
- c. MAP 95;
- d. MAP 2000;
- e. Formal complaints;
- f. Corrective action plans;
- g. Prior Authorizations; and
- h. Level of Care confirmations.

In accordance with 907 KAR 1:145, 907 KAR 1:155, 907 KAR 1:160, 907 KAR 1:170, 907 KAR 1:835, 907 KAR 3:090, 907 KAR 3:100, and 907 KAR 3:210, financial reports, service records, and incident reports regarding CDO shall be retained for at least six (6) years from the date that a covered service is provided. For a minor, the record shall be retained for at least three (3) years from the date that a service is provided, or after the recipient reaches the age of majority under state law whichever is longest.

CONSUMER DIRECTED OPTION General Requirements of the Support Broker	DAIL-CDO-6.8
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General Requirements of the Support Broker

It shall be the policy of the support brokerage agency to further establish quality management practices including but not limited to adherence to support broker qualifications, hiring practices, staff training, and overall responsibility necessary for the effective implementation and ongoing provision of support broker services. If policies and procedures are not in place for CDO, then the agency will be held accountable.

A support broker is an individual chosen by the consumer from the AAAIL or CMHC to provide training, technical assistance, and supports to the consumer, as well as help the consumer manage his/her approved CDO budget and assist the consumer in any other aspects of CDO.

A support broker shall have the same qualifications as a case manager as set forth in the following Kentucky Administrative Regulations (KAR) according to the appropriate waiver program:

907 KAR 1:145	Supports for Community Living Services for an Individual with Mental Retardation or a Developmental Disability
907 KAR 1:160	Home and Community Based Waiver Services
907 KAR 1:835	Michelle P Waiver Services and Reimbursement
907 KAR 3:090	Acquired Brain Injury Waiver Services
907 KAR 3:210	Acquired Brain Injury Long-Term Care Waiver Services and Reimbursement

Support brokers shall meet one of the following qualifications:

- (1) Be a Registered Nurse (RN) and have one (1) year or more of experience as a professional nurse;
- (2) Be a Licensed Practical Nurse (LPN);
- (3) Be a Social Worker (an individual with a bachelor's degree in social work, sociology, or a related field or licensed by the Kentucky Board of Social Work);
- (4) Be a Certified Psychologist with autonomous functioning;
- (5) Be a licensed Psychological Practitioner;
- (6) Be a licensed Marriage and Family Therapist (LMFT); or
- (7) Be a licensed Professional Clinical Counselor (LPCC).

CONSUMER DIRECTED OPTION General Requirements of the Support Broker	DAIL-CDO-6.8
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A Support broker shall:

- (1) Initially receive and participate in a minimum of fourteen (14) hours of CDO training, conducted by DAIL, within the first six (6) months of hire;
- (2) Annually receive and participate in a minimum of sixteen (16) hours annual in-service training approved by DAIL concerning topics that relate to CDO and/or populations served;
- (3) Participate in all DAIL-mandated CDO trainings;
- (4) Be the first level of contact with consumers. As a result, the support broker is required to be available twenty-four (24) hours per day, seven (7) days a week. The support broker must ensure that the consumer has any needed contact information, so that phone calls can be made when needed;
- (5) Maintain a caseload that does not exceed 40 consumers; and
- (6) Must submit to a criminal background check and not have been convicted of committing a felony, sex crime, and/or violent crime as defined in KRS 17.165 (1) through (3) prior to being offered employment or acting in an employee role.

Support brokers must adhere to Medicaid provider requirements established by DAIL and DMS. Verification of support broker criminal background check, training(s), and staff hire dates must be found in personnel files located at the AAAIL or CMHC.

CONSUMER DIRECTED OPTION Responsibilities of a Support Broker	DAIL-CDO-6.9
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Responsibilities of a Support Broker

Support broker duties include the following:

- (1) Brokering services for individuals receiving CDO and blended services;
- (2) Training the consumer and/or representative;
- (3) Providing technical assistance to the consumer;
- (4) Coordinating services and community resources for the consumer;
- (5) Monitoring direct care service(s) to ensure that the consumer's health, safety and welfare is maintained;
- (6) Assisting in developing a person-centered plan of care (including an emergency back-up plan, support spending plan, and budget);
- (7) Ensuring a face-to-face visit is conducted monthly with the consumer and representative, if applicable;
- (8) Ensuring accurate and detailed documentation in case notes; and
- (9) Ensuring the consumer has a DAIL-VR-01 (Voter Registration Rights and Declination Form) to complete if consumer so chooses.

The training and technical assistance provided by support broker will help the consumer to budget correctly and avoid overspending, as well as provide guidance on recruiting, hiring, supervising, and firing employees. The benefit total shall be based on need, utilization, and existing service limitations.

Support brokers at a minimum, shall make a monthly face-to-face visit with the consumer to assure that delivery is in accordance with the consumer's plan of care and support spending plan, and is adequate to meet the consumer's needs according to regulation.

Support brokers shall initially and monthly verify consumer's Medicaid eligibility and applicable waiver eligibility through the Kentucky Health Net at www.kymmis.com.

CONSUMER DIRECTED OPTION Responsibilities of the Financial Management Agency	DAIL-CDO-6.10
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Responsibilities of the Financial Management Agency

The ADD and CMHC shall provide financial management services, which includes having a fiscal management agency that shall:

- (1) Assist the consumer to manage funds contained in the consumer's approved CDO budget;
- (2) Submit to the support broker the standardized DAIL approved monthly budget expenditure report for each consumer, on or before the 15th of each month following the previous month of service. The expenditure report shall include the following:
 - a. Provision of monthly financial expenditures to-date; and
 - b. Monthly allocations of budget and hours utilized, as well as percentage of budget utilized.
- (3) Process timesheets and payroll for providers at a minimum of twice per month. Payroll check should have, at minimum, the following information:
 - a. Provider's name and mailing address;
 - b. Number of hours worked; and
 - c. Hourly pay rate.
- (4) Maintain a copy of consumer's prior authorization covering the current level of care dates;
- (5) Maintain copies of provider timesheets. Original timesheets shall be located in the consumer or employee file;
- (6) Maintain a copy of each provider's Employee/Provider Contract with the consumer to ensure the total hours on the timesheet submitted by each provider match the hours allotted to the provider;

CONSUMER DIRECTED OPTION Responsibilities of the Financial Management Agency	DAIL-CDO-6.10
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- (7) Provide the support broker with a CDO provider employment packet which shall include the following:
- a. Employment Application;
 - b. Administrative Office of the Courts Criminal Background Check form;
 - c. Kentucky Board of Nursing / Nurse Aide registry Check form;
 - i. Search by provider name. If one or more names are listed for the entry, click “select all” and validate selection. If no provider is listed on the registry, note at bottom of printout, “provider not listed on registry check”, if a name appears to be on the registry, contact the Kentucky Board of Nursing via telephone at 502-429-3300 or 1-800-305-2042 to verify provider by social security number. If individual is not verified as the provider for the consumer, note at bottom of printout, “provider for consumer has been verified by KBN not to be individual on registry.”
 - d. Central Registry Check form;
 - i. This check is only required by the SCL, ABI, or ABI-LTC waiver programs; however, it is best practice to obtain and review results with consumer. After reviewing the results, if the consumer still chooses to hire the provider, require the consumer to sign a disclosure that he/she has been informed of the results and still chose to hire provider.
 - e. CDO Employer/Provider Contract;
 - f. I-9 form (Employment Eligibility Verification);
 - i. To sustain best practice, it is recommended by DAIL that the financial manager maintain two copies of identification that have been verified on all providers.
 - g. W-4 form (Employee’s Withholding Allowance Certificate, Federal); and
 - h. K-4 Revenue form (Employee’s Withholding Exemption Certificate, State of Kentucky).
- (8) Review documentation to ensure services were provided as specified on timesheet;

CONSUMER DIRECTED OPTION Responsibilities of the Financial Management Agency	DAIL-CDO-6.10
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- (9) Maintain on file consumer's IRS Form 2678 (Employer/Payer Appointment of Agent) or SS4 (Application for Employer Identification Number);
- (10) Complete fiscal accounting functions and expenditure reports;
- (11) Comply with all tax reporting, employment, and wage laws;
- (12) Maintain an audit trail of disbursement of funds;
- (13) According to MAP 552 or Kentucky Health Net printout, bill and collect patient monthly liability from consumer; and
- (14) Provide written notification to recommend termination from CDO to the support broker within twenty-four (24) hours following payment due date (as determined by the financial manager) if consumer fails to pay patient liability.

The financial manager will be responsible for ensuring prior authorization, paying for goods and services, billing Medicaid, and tracking reimbursements.

The financial manager will provide assistance with paying employer and unemployment compensation taxes, appropriate local taxes, processing employment information, reviewing records to ensure correctness, paying providers, and paying employees in accordance with the fair labor standards act, as well as local, state, and federal employment-related laws.

The financial manager will ensure all billed services follow the prior authorization, do not exceed the dollar amount allotted for the current month, and do not put a CDO provider in overtime status during any pay period unless one-time, short-term (less than 1-2 weeks) extenuating circumstances have occurred. If a CDO provider exceeds the hours allotted on the Employee/Provider Contract, the financial manager shall notify the support broker who shall contact the consumer to discuss the over-use of provider hours allotted on the contract agreement. The support broker shall have the consumer either resubmit a new timesheet if an error was made, inform the consumer that the provider must balance the remaining hours to not exceed the Employee/Provider Contract hours for the month, or confirm whether the consumer would qualify for a budget exception.

CONSUMER DIRECTED OPTION Responsibilities of the Financial Management Agency	DAIL-CDO-6.10
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In accordance with KRS 205.5606, the financial manager using the approved CDO budget shall deduct from the gross annual budget for services, any appropriate federal, state, and local taxes prior to the development of the support spending plan.

The financial manager shall keep the consumer's IRS 2678 Employer/Payer Appointment of Agent, or SS4 Application for Employer Identification Number recognizing the consumer as his/her own employer. This form shall be completed and placed in consumer's file at the AAAIL or CMHC.

The financial manager shall review timesheets prior to processing. If timesheets have inappropriate corrections (white-outs or write-overs), are not completed in blue or black ink, or services provided do not align with the administrative regulation service definition, the timesheet shall be returned to the support broker so that consumer can produce a corrected copy.

After the consumer has signed the MAP 2000 and the support broker has begun providing support brokerage services, the financial manager will track and collect any patient liability that a consumer may have incurred. Patient liability is determined by the DCBS at the time Medicaid eligibility is approved. The financial manager shall only collect the amount the support broker would be reimbursed for a support brokerage service. If at any time the consumer does not pay his/her required patient liability, the financial manager is responsible for providing written notification to the support brokerage agency within twenty-four (24) hours of not receiving the patient liability. The support brokerage agency may start the process of requesting immediate termination; however, it is DAIL's recommendation that a corrective action plan (CAP) be implemented prior to immediately terminating from CDO services.

Financial managers shall not be a provider of services or supports other than financial management services to any consumer enrolled in CDO. Financial managers cannot serve as a consumer's designated representative. Financial managers must also adhere to Medicaid provider requirements established by DAIL, DMS, and the Department of Revenue.

The DMS is responsible for providing service payments, and will not reimburse for mismanagement or miscalculation errors made by the ADD, AAAIL, CMHC, support brokerage agency, or consumer.

CONSUMER DIRECTED OPTION Responsibilities of the Financial Management Agency	DAIL-CDO-6.10
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Questions concerning service payments and the budget process should be directed towards Medicaid at (502) 564-5560.

CONSUMER DIRECTED OPTION Administrative Responsibilities of the Department for Aging and Independent Living (DAIL)	DAIL-CDO-6.11
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Administrative Responsibilities of the Department for Aging and Independent Living (DAIL)

DAIL shall be responsible for the statewide administration of CDO. In keeping with the statutory and regulatory mandates, DAIL shall be responsible for providing direction to the ADDs, the AAAILs, and the CMHCs in effectively and efficiently administering CDO. DMS shall establish and make available the statewide policies and procedures essential for fiscal and program operation. DAIL will ensure implementation of the statewide policies and procedures established by DMS. DAIL shall solicit and utilize input from the ADDs, CMHCs, advisory councils, agencies, organizations, citizens, advocates, and especially recipients of CDO and their families in the administration of the program.

DAIL shall:

- (1) Develop and revise, as necessary, program and fiscal reporting requirements for the program;
- (2) Provide training and maintain a viable working relationship with the support brokerage agency and the financial management agency through monitoring and technical assistance functions;
- (3) Maintain and revise, as necessary, DMS-approved CDO forms and manuals;
- (4) Monitor, at least annually, ADD, AAAIL, and CMHC administration of CDO including the provision of any financial management and support brokerage services;
- (5) Ensure all aspects of training requirements are met and followed, including but not limited to, support broker, verification of person-centered planning, abuse, neglect, fraud, and exploitation of consumer and providers, provider timesheet/service documentation, patient liability, adherence to approved plan of care and budget development, maintenance of consumer's health, safety, and welfare;

CONSUMER DIRECTED OPTION Administrative Responsibilities of the Department for Aging and Independent Living (DAIL)	DAIL-CDO-6.11
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- (6) Impose citations and/or corrective action plans when necessary should the support brokerage agency or financial management agency not adhere to the CDO standards outlined in the Kentucky Administrative Regulations, provider letters, standard operating procedures, and contractual agreement;
- (7) Conduct, at least annually, a random sampling of face-to-face visits with consumer and representatives, if applicable;
- (8) Provide or assist with training and technical assistance in situations where assistance is needed due to problems in coordination with other programs or agencies, difficult consumer situations, and complaints;
- (9) Provide periodic updates and provider letters for continuing education and support;
- (10) Forward written requests for budget adjustments (exceptions) for CDO consumers to DMS;
- (11) Submit ongoing monthly, quarterly, and annual reports to DMS;
- (12) Submit monitoring monetary deficiencies to DMS;
- (13) DMS may perform second-line reviews or audits and may impose other penalties, including recoupment of monies, as necessary following the second-line review or audit;
- (14) Develop other protocols, guidelines or CDO requirements, when the need has been identified.

CONSUMER DIRECTED OPTION Referral and Assessment	DAIL-CDO 6.12
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Referral and Assessment

The following outlines per each Kentucky Administrative Regulation (KAR) who may make a referral for assessing an individual that may meet eligibility for waiver services:

- (1) ABI – the individual seeking services, or family member or legal representative of the individual
- (2) ABI-LTC – the individual seeking services, or a family member or legal representative of the individual
- (3) HCB – the individual seeking services, family member or legal representative of the individual, physician, physician assistant, or an Advanced Registered Nurse Practitioner (ARNP)
- (4) MP – the individual seeking services, family member or legal representative of the individual, physician, physician assistant, Qualified Mental Retardation Professional (QMRP), or ARNP
- (5) SCL – the individual seeking services, or a family member or legal representative of the individual

An assessment contact or request may begin while the potential waiver participant is in the hospital, nursing facility, their own home or another place of residence; however, the assessment must be completed in the individual’s home during a face-to-face visit.

It is the responsibility of the support broker to ensure that an assessment is completed for each individual requesting CDO services. As required by DAIL and DMS through CDO, the support broker must make an initial contact via telephone with the individual after receiving a referral for services to explain the tenets of CDO, answer any questions, and schedule a home visit to complete the assessment. The total time from receiving the referral and completing the assessment is seven (7) calendar days. The date of referral for waiver/CDO services shall be documented in the case notes. If unforeseen circumstances will not allow the assessment to be complete within seven (7) calendar days, the support broker shall document the reason for the delay in the case notes along with a scheduled date for the assessment to be complete. Although the MP waiver regulation does not specify a timeline for the assessment to be complete, it is the expectation of DAIL that the

CONSUMER DIRECTED OPTION Referral and Assessment	DAIL-CDO 6.12
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assessment be complete within the seven (7) calendar days to ensure an individual in need of services starts the CDO process in a timely manner.

According to the MAP 350 form (Long Term Care Facilities and Home and Community Based Program Certification Form), the individual has the freedom of choice to choose what agency provides his/her assessment or reassessment services. The following entities are authorized to conduct a MAP 351 assessment/reassessment:

- (1) ADHC;
- (2) Community Mental Health Centers - ABI Provider, SCL Provider, MP Provider (solely responsible for completing MP assessments according to contract with Medicaid);
- (3) AAAIL - Support brokers; and
- (4) Traditional Home Health Agencies.

An assessment shall include a comprehensive summary identifying an individual's needs and services that cannot be managed or arranged by the individual or individual's family. The assessment shall be completed on the MAP 351 form (Medicaid Waiver Assessment). The assessment is used to evaluate the individual's physical health, mental health, social supports, natural supports, and their home environment. The assessment shall be completed with the individual and legal representative/guardian, if applicable. Unless the individual is able to complete the task independently, questions shall be answered in detail. It is imperative that the assessment addresses who assists with each task and the frequency of assistance with each task that the individual is unable to complete independently. It is important that while completing the assessment with the individual, the support broker tries to remove any distractions or other individuals from the room that may persuade the individual's personal responses.

DMS contracts with a QIO to approve and prior authorize services requested on the individual's plan of care. Initial waiver assessment packets must be either submitted via fax (ABI, ABI-LTC, MP, and SCL) and received by QIO or called in (HCB) to QIO as soon as possible.

The support broker will obtain a verbal LOC via telephone for an HCB assessment if the individual meets patient status criteria for nursing facility services as established in 907 KAR 1:022. The support broker will receive a faxed 'facility report form', as well as a letter copy of the LOC Confirmation if the individual meets ICF-MR-DD patient status requirements as established in 907 KAR 1:022 for the MP and SCL

CONSUMER DIRECTED OPTION Referral and Assessment	DAIL-CDO 6.12
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assessments or if the individual meets nursing patient status criteria for nursing facility services as established in 907 KAR 1:022 for ABI and ABI-LTC assessments.

If the support broker does not receive a LOC for the assessment, QIO will call to notify the support broker that LOC is pending and under Physician Review. Physician Reviews may take up to 5-7 business days before completion. If denied, a letter is sent to the support broker within 3-5 business days with further steps for the support broker to take. If approved, a letter of approval is also sent to the support broker. The support broker can also check periodically on the Kentucky Health Net website: www.kymmis.com.

Initial assessment packets submitted and received by QIO greater than sixty (60) calendar days after the date that the assessment was complete shall be returned without a review and a new assessment shall have to be completed.

Each KAR requires a MAP 351 to be completed by an individual with qualifications of a support broker. Below is a list of the five (5) 1915c waivers programs for CDO and which waivers require only one (1) individual assessor signature or an assessment team of two (2) individuals to complete the MAP 351:

- ABI:** 1 signature required - support broker/case manager
- ABI-LTC:** 1 signature required - support broker/case manager
- HCB:** 2 signatures required - 1 support broker/case manager and 1 RN, or 2 RN's
- MP:** 2 signatures required - 1 support broker/case manager and 1 RN, or 2 RN's
- SCL:** 1 signature required - support broker/case manager

If at the time of referral for CDO services, the individual has a current MAP 351 assessment complete, the support broker shall coordinate with the assessment agency and obtain a copy for the support broker records. Upon receipt of the assessment, the support broker will ensure Section XIII, ***'Assessment/Reassessment forwarded to support broker/case manager provider'*** is complete. During the initial home visit, the support broker will review the completed assessment with the individual and amend any changes that may have occurred since the previous assessment was complete. If amendments are needed, the support broker shall make the change to the left side of the comment box, and initial and date each amendment. Once the assessment is reviewed thoroughly, the support broker will sign, including title and date, Section XIII.

**CONSUMER DIRECTED OPTION
Referral and Assessment**

DAIL-CDO 6.12

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Support Brokers shall document the date and time that verbal LOC was obtained by QIO on the MAP 351 assessment for HCB assessments.

CONSUMER DIRECTED OPTION Reassessments	DAIL-CDO 6.13
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Reassessments

A reassessment service follows the same procedures as outlined in the assessment service. A reassessment service determines the continuing need for a waiver service, and if appropriate, a CDO service. A reassessment service shall not be retroactive, must be conducted at least every twelve (12) months, and must be completed by an authorized assessment provider or support brokers who shall submit to QIO no more than twenty-one (21) days prior to the expiration of the current level of care certification period to ensure that certification is consecutive.

While the CMHC is the only agency that may provide the assessment or reassessment service for MP consumers, it is the Support Broker's responsibility to ensure the CMHC is notified with ample time to complete the reassessment when warranted.

If a consumer's physical health, mental health, social supports, natural supports, or home environment changes throughout the year of his/her level of care dates, it is the responsibility of the support broker to update the MAP 351 form to reflect the change(s). If a change occurs, the support broker shall amend the assessment, initial and date the change, and sign and date the last page of the assessment under Section XIII (signatures).

It is an acceptable practice to take the MAP 351 form to the consumer's home – on a monthly basis - and make any necessary updates while the support broker conducts a face-to-face home visit with them.

CONSUMER DIRECTED OPTION Initial Home Visit Requirements	DAIL-CDO-6.14
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Initial Home Visit Requirements

When a support broker receives a referral for CDO services, a face-to-face home visit will be completed with the consumer within seven (7) calendar days. The home visit shall entail at a minimum:

- (1) Thoroughly completing a MAP 351 form (Assessment) or updating an assessment for an existing waiver recipient;
- (2) Completing the MAP 350 form (Long Term Care Facilities and Home and Community Based Program Certification);
- (3) Completing the MAP 2000 form (Initiation/Termination of CDO) for a new or existing waiver recipient;
- (4) Completing a Rights, Responsibilities and Risks Statement;
- (5) Completing a MAP 109 form (Plan of Care) for a new or existing waiver recipient;
- (6) Facilitating the completion of IRS 2678 or SS4 form, identifying the consumer as the employer; and
- (7) Facilitating the completion of the Adaptation of Quality Life Changes Survey.

During the initial home visit, the support broker shall explain CDO and thoroughly review the Rights, Responsibilities and Risks form. At this time, the consumer may choose to designate a representative, in which case, the designated representative will be required to review the Rights, Responsibilities, and Risks form, and sign and date it, as well as complete the MAP 2000 with all required signatures.

Although it is not required to be completed upon the initial home visit, the MAP 109 form is required to be completed within thirty (30) calendar days from the referral date. However, it is DAIL's recommendation that it be completed during the initial visit.

Initial training involving the support broker, consumer, and representative, if applicable, should occur during the initial home visit, or may be scheduled within

CONSUMER DIRECTED OPTION Initial Home Visit Requirements	DAIL-CDO-6.14
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thirty (30) calendar days of initial contact. It must be completed prior to direct services being initiated.

If the support broker does not have a MAP 10 form (Waiver Services Physician's Recommendation) or statement of need for long-term care services, the support broker shall initiate the process of obtaining the MAP 10 from the consumer's physician.

CONSUMER DIRECTED OPTION Consumer/Representative Training	DAIL-CDO 6.15
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Consumer/Representative Training

Training for the consumer/representative must include topics such as:

- (1) Principles of self determination;
- (2) Employee contracts;
- (3) Employee background checks;
- (4) Timesheets;
- (5) Budget management responsibilities;
- (6) Person-centered planning;
- (7) Abuse, neglect, and exploitation;
- (8) Fraud;
- (9) Corrective Action Plans;
- (10) Potential terminations;
- (11) Naming someone as 'backup' for primary employee on the POC emergency backup plan;
- (12) Any additional topics required by the support brokerage agency, DAIL or DMS.

Verification of consumer/representative training must be found in the consumer's file located at the AAAIL or CMHC.

Person-centered planning principles are the cornerstone of quality service, and shall be used to guide interactions and support for CDO consumers.

Person-centered planning supports for individuals with disabilities will:

- (1) Ensure dignity and respect for each person as a valued individual;

CONSUMER DIRECTED OPTION Consumer/Representative Training	DAIL-CDO 6.15
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- (2) Be entitled to the rights, privileges, opportunities, and responsibilities of community membership;
- (3) Be supported and encouraged to develop personal relationships, learning opportunities, work and income options, and worship opportunities as full participants in community life;
- (4) Be based on individually determined goals, choices, and priorities;
- (5) Be easily accessed and provided regardless of the intensity of individual need;
- (6) Be afforded the opportunity to direct the planning, selection, implementation, and evaluation of their services;
- (7) Require that funding be flexible and cost effective and make use of natural, generic, and specialized resources;
- (8) Be the primary decision makers in their own lives; and
- (9) Be evaluated based on outcomes for individuals.

CONSUMER DIRECTED OPTION Plan of Care and Support Spending Plan	DAIL-CDO-6.16
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Plan of Care and Support Spending Plan

It is the responsibility of the support broker to ensure a MAP 109 form or Plan of Care (POC) is completed for each consumer within thirty (30) calendar days from the date of referral.

A consumer's POC must be individualized to meet the consumer's specific needs, and include services and supports based upon therapeutic goals. All services and/or goods identified on the POC must reduce the need for personal care or enhance independence within a consumer's home and community.

The POC must include specific individualized goals and daily interventions, in addition to specific services needed to accomplish the goals identified. The POC must also include the provider of each service. The identified service shall further include the amount, frequency, and duration or length of time the expected service should last. All services and supports, whether or not funded through the Medicaid waiver shall be reflected on the POC. This may include details about natural supports that are used to meet the consumer needs.

The support spending plan must also reflect the amount of the consumer's approved CDO budget after the appropriate employer taxes are deducted. The POC will additionally include the LOC dates up to twelve (12) months. Any traditional waiver services provided must be included on the support spending plan. In order to be covered, a CDO service or good must be added to the support spending plan, as well as who is providing the service and his/her hourly pay rate. The hourly pay rate shall not exceed Medicaid's upper limit pay rates for services.

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Key:

PC = Personal Care	HM = Homemaking	AC = Attendant Care	CC = Companion Care	R = Respite
CLS = Community Living Supports	G/S = Goods/Services	ADT = Adult Day Training	SE = Supported Employment	MHA = Minor Home Adaptation

HCB	Michelle P	SCL	ABI	ABI Long-Term Care
Annual Max: \$34,453	Annual Max: \$40,000 With Exception: \$63,000	Annual Max: \$140,000	Annual Max: \$67,533	Annual Max: \$67,533
PC \$30.00/hr	PC \$30.00/hr	CLS \$22.16/hr	PC \$22.24/hr	CLS \$22.24/hr
HM \$26.00/hr	HM \$26.00/hr	R \$11.08/hr	CC \$22.24	R \$23,040.00/yr
AC \$11.50/hr	AC \$11.50/hr	G/S no limit	R \$5,376.00/yr	G/S no limit
R \$4,000.00/yr	R \$4,000.00/yr	ADT \$10.00/hr	G/S no limit	MHA \$2,000.00/yr
G/S no limit	CLS \$22.16/hr	SE \$22.16	MHA \$2,000.00/yr	SE \$3,192.00/yr
MHA \$475.00/yr	G/S no limit			
	MHA \$475.00			
	SE \$22.16/hr			
	ADT \$10.00/hr			

Unit limits set per each KAR are identified below and shall be followed on the support spending plan.

- **ABI** – Respite shall be limited to 336 hours per calendar year;
- **ABI-LTC** – CLS shall be limited to no more than forty (40) hours per calendar week and respite shall be limited to 1,440 hours per calendar year;
- **HCB** – HM service shall be limited to no more than four (4) *units*/two (2) *hours* per calendar week;
- **MP** – CLS shall be limited to sixteen (16) hours per day alone or in combination with ADT and SE; and

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- **SCL** – CLS shall be limited to sixteen (16) hours per day alone or in combination with ADT, children’s day habilitation, and SE, and respite shall be limited to 1,440 hours per calendar year.

The POC must include provider names, addresses, telephone numbers, and provider numbers or Social Security numbers of individual employees. A clinical summary of the consumer must also be included. Information should include, but not be limited to, the consumer’s diagnosis, how the diagnosis(es) affects the consumer, and natural supports.

The emergency back-up plan is also a required component of the consumer’s POC. It identifies who will be used to “back-up” the consumer’s primary employee(s) should the individual(s) become unavailable. It should also include directions on how to assist the consumer in an emergency. Examples may include: if the consumer has a seizure, a fall, or a behavior that might be harmful to the consumer or another individual. The person who is responsible in the event of an emergency must be named on the POC, include a telephone number at which to reach the individual, receive the same training as the primary employee, and be physically able to provide the needed services to the consumer. This person may be paid or unpaid. Paid emergency back-up employees must submit to and meet the regulatory requirements in order to serve as a back-up employee. CDO representatives may serve as an unpaid emergency back-up.

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Prior Authorization for CDO Services

The support broker is required to obtain a prior authorization (PA) for any waiver service, including any goods, prior to the date of service expenditure. In order to obtain a PA, the support broker must submit via fax or mail the following documents per the appropriate waiver to QIO.

To obtain an **initial** PA for all waivers, the MAP 351 form (Assessment) must be completed and submitted to QIO within thirty (30) days of the completed assessment, as well as the MAP 2000. All other required documents listed below, do not have a specified timeframe for submission to QIO.

- **ABI** – Allocation letter (obtained from DMS);
MAP 350
MAP 351
MAP 24C
MAP 2000
MAP 109
MAP 10
CDO Budget (submitted from support brokerage agency and Medicaid).

- **ABI-LTC** – same documentation required as ABI.

- **HCB** – MAP 350
MAP 351
MAP 2000
MAP 109
MAP 10
MAP 95, if requesting goods and services or equipment
CDO Budget (submitted from support brokerage agency and Medicaid).

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- **MP** – MAP 350
MAP 351
MAP 24
MAP 2000
MAP 109
MAP 10
MAP 95, if requesting good and service or equipment
CDO Budget (submitted from support brokerage agency and Medicaid).

- **SCL** – Allocation letter
MAP 350
MAP 351
Current physical exam (completed within 1 year)
Psychological evaluation
Social history (completed within 1 year)
MAP 24C
MAP 2000
MAP 109
MAP 10
CDO Budget (submitted from support brokerage agency and Medicaid).

To obtain a **recertification** PA for all waivers, the MAP 351 form must be completed and submitted to QIO within twenty-one (21) days of LOC expiration date. All other required documents listed below, must be submitted to QIO within sixty (60) days of the consumer's level of care expiration date.

- **ABI** – MAP 350
MAP 351
MAP 2000
MAP 109
MAP 10
CDO Budget (submitted from support brokerage agency and Medicaid)

- **ABI-LTC** – same documentation required as ABI.

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- **HCB** – MAP 350
MAP 351
MAP 2000
MAP 109
MAP 10
MAP 95 if requesting goods and services or equipment; and
CDO Budget (submitted from support brokerage agency and Medicaid)

- **MP** – MAP 350
MAP 351
MAP 2000
MAP 109
MAP 10
MAP 95 if requesting good and service or equipment; and
CDO Budget (submitted from support brokerage agency and Medicaid)

- **SCL** – MAP 350
MAP 351
MAP 2000
MAP 109
CDO Budget (submitted from support brokerage agency and Medicaid)

QIO reviews the PA request and issues an authorization or denial for each category of service. If approved, a PA letter will be issued. The PA is also available to the support brokerage agency and financial manager via the Kentucky Health Net website, www.kymmis.com. If QIO receives an incomplete packet from a support broker, a Lack of Information (LOI) letter will be sent by QIO to the support broker and consumer, requesting what information is needed in order to issue a PA. The support broker will have fourteen (14) calendar days from date listed on letter to submit the requested information back to QIO.

QIO Phone #: 1-800-929-2392
QIO Fax #: 1-800-807-8843

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CDO Service Packages

The structure of the service packages allows the flexibility of shifting the amount of units that have been prior authorized among the same service package as the consumer's needs change according to their POC. There are three (3) categories that make up a budget: Home and Community Supports (HCS), Community Day Supports, and Goods and Services/Minor Home Adaptation (MHA). There shall be no funds floating between each category. The flexibility offered within each category occurs without the need for additional prior authorizations as needs change. The flexibility in direct services is billed under the s5108 bundle code. The support broker shall ensure that the consumer is kept up-to-date on the monthly expenditures and remaining budget balance each month during the face-to-face visit.

Following is a summary of the three (3) CDO service packages:

- (1) **CDO Home and Community Support Services** – These supports facilitate independence and promote integration into the community for individuals residing in their own home and are available only under CDO.

Supports are provided **one-on-one** and include assistance, support (including reminding, observing, and/or guiding) and/or training in activities such as meal preparation, laundry, routine household care and maintenance, activities of daily living such as bathing, eating, dressing, personal hygiene, shopping, money management, reminding, observing, and/or monitoring of medications, and non-medical care. These supports also include socialization, relationship building, leisure choice, and participation in generic community activities.

- (2) **CDO Community Day Support Services** – These services must be provided in a community setting and be available only under CDO. The services must be tailored to the consumer's specific personal outcomes related to the acquisition, improvement, and retention of skills and abilities to prepare and support the consumer for work or community activities, socialization, leisure, or retirement activities.

Home and Community Supports and Community Day Supports shall be based upon therapeutic goals and not be diversional in nature, nor are they to replace other work or daily activities.

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(3) **Goods and Services/Minor Home Adaptation** – A consumer may request that a portion of their budget be used to purchase goods and services that are individualized and included in the POC and support spending plan; however, there are rules and guidelines for how consumers can and cannot spend budget dollars. The authorization for goods and services cannot exceed the Medicaid maximum limitation amounts. A consumer may purchase goods and services within their budget that directly relate to the goals, interventions, and expected outcomes that the consumer has helped outline in their individualized POC. In order to be covered, any service or goods must be included in the POC and support spending plan, and be approved by Medicaid. Goods and services must reduce the need for personal care or enhance independence within the home or community. Examples may include environmental and minor home adaptation (HCB \$500, MP \$500, ABI \$2,000, and ABI LTC \$2,000 limit per a calendar year), assistive technology or assistive-type goods and services, incontinent supplies, and nutritional supplements. Permanent environmental and minor home adaptations are not permitted for individuals renting their home. However, Medicaid may for example authorize a grab bar that uses suction cups that would not be permanently installed.

Items that may NOT be purchased include, but are not limited to:

- Services covered by the Medicaid State Plan including the Durable Medical Equipment Program, Medicare, or other third parties including education, home-based schooling, and vocational services or through any other source
- Services, goods, or supports provided to or benefiting persons other than the individual consumer such as:
 - Room and board
 - Personal items and services not related to the disability
 - Vacation expenses
 - Vehicle modifications and repairs
 - Wood floors
 - Fences
 - IPads
 - Health club memberships
 - Community membership dues
 - Recreational activities
 - Creative arts

CONSUMER DIRECTED OPTION CDO Service Packages	DAIL-CDO 6.18
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- Cell phones
- Specialized toys
- Play therapy
- Hippo-therapy
- Massage therapy
- Exercise equipment
- Educational opportunities not covered by other public health programs
- Experimental goods or services
- Chemical or physical restraints
- **Transportation for medical appointments cannot be consumer directed.**

NOTE: Transportation is provided for Medicaid recipients under the state plan and utilization under waivers is duplicative.

It is the support broker's responsibility to ensure goods and services are purchased within the regulatory guidelines. The support broker should seek consultation from their supervisor who may also in turn, consult with the state, if any questionable goods or services are requested or purchased by a consumer.

CONSUMER DIRECTED OPTION Consumer Budgets	DAIL-CDO 6.19
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Consumer Budgets

In order for the consumer to obtain a CDO budget, the support broker must email a budget request form to DMS at cdobudget.request@ky.gov. The CDO budget is the amount of funds a consumer has available over the course of twelve (12) months for direct service delivery and to purchase goods and services that have been authorized by Medicaid.

The support broker shall provide the consumer with a monthly budget expenditure report that separates the total budget allocated, total hours allocated, budget utilized, hours utilized, and percentage of budget utilized per month.

DMS establishes a budget based on KAR criteria for each waiver program. For consumers who are currently receiving Medicaid waiver services from a waiver program authorized to provide CDO, the budget is based on the assessment, POC, and the cost of Medicaid services used in the past (historical costs) to meet their individual personal care needs, minus 5% administrative costs.

If the consumer has never received Medicaid waiver services, their budget is based on the assessment, POC, and if applicable, the average utilization cost of Medicaid waiver services used by others in the same waiver to meet their care needs, minus 5% administrative costs.

Once the consumer's budget is approved, DMS will email the CDO budget to the support broker and CDO supervisor. The support broker will then access the information and ensure the approved CDO budget matches the support spending plan prior to submitting the completed PA packet to the QIO for processing.

Using the approved CDO budget, the financial manager shall deduct from the gross annual budget for services amount (after administrative 5% withhold) any appropriate federal, state, and local taxes.

The following table reflects the maximum Medicaid budget a waiver consumer can receive to help maintain placement in their home. In addition to Medicaid funded services, natural supports within in the home and community must also be considered. The assessment and plan of care guides the development of the budget.

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Waiver Program	Maximum Gross Dollar Amount	Limitations
ABI	\$67,533.00	Annually
ABI LTC	\$67,533.00	Annually
HCB	\$34,453.00	Annually
MP	\$40,000.00 - \$63,000.00	Annually
SCL	\$140,000.00	Annually

CONSUMER DIRECTED OPTION Budget Adjustments / Exceptions	DAIL-CDO 6.20
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Budget Adjustments / Exceptions

It is the policy of the support broker, financial manager and CDO consumer to plan services and supports adequate to meet the consumer's needs without exhausting the allocated budget. When extenuating and catastrophic circumstances occurs that demonstrate a greater need than their CDO budget allows, the budget may be increased for the purpose of preventing institutionalization and the protection of the consumer's health, safety and welfare. Regardless of the extenuating and catastrophic circumstances, the budget shall not exceed the regulatory annual cost of services provided to individuals in a nursing facility or ICF-MR-DD. The table of the annual caps per waiver is located in DAIL- CDO 6.19 - Consumer Budgets of the standard operating procedures.

The support broker shall submit a written request for a budget to be increased to DAIL and one (1) the following level criteria's must be met:

(1) Level I criteria:

- a. Consumer's needs exceed the initial budget;
- b. Consumer's needs do not exceed the original plan of care;
- c. Consumer has not been receiving services for more than ninety (90) days; and
- d. Consumer's needs are not catastrophic in nature as defined in Level II.
- e. Examples include the following:
 - Consumer is new to waiver;
 - Consumer's current POC is not being fulfilled; or
 - Consumer is utilizing traditional waiver services and chooses to transfer to CDO.

(2) Level II criteria:

- a. A catastrophic change in the consumer's physical condition has occurred, which has resulted in additional major loss of function, and limitation to ADLs and IADLs (i.e. consumer has been hospitalized, received a new diagnosis, or experienced cognitive and/or physical deterioration);

CONSUMER DIRECTED OPTION Budget Adjustments / Exceptions	DAIL-CDO 6.20
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- b. A catastrophic change in the consumer's caregiver circumstances has occurred, such as the death or loss of functioning of a caregiver or a caregiver is starting or returning to work (i.e. consumer's primary caregiver is accruing more work—from part-time to full-time, consumer has switched services from a traditional to CDO provider, consumer has aged out of EPSDT services, consumer has graduated from school, consumer has minimized ADHC or ADT participation, or consumer has switched from a state to federal funding source.
- c. A catastrophic change in the consumer's environmental living arrangement has occurred, which has resulted in the need to relocate them into different living conditions (i.e. consumer has experienced an involuntary eviction, consumer has relocated from a residential program, or consumer has lost their house to a natural disaster.

If an exception request does not meet the criteria for either level, it should not be submitted.

A completed exception request packet must be scanned and emailed to toniaA.wells@ky.gov, brook.jenkins@ky.gov, and evan.charles@ky.gov. Place in the subject line: exception – consumer's first initial and complete last name. The packet shall include at a minimum:

- (1) DAIL-100 form;
- (2) Plan of care (MAP 109);
- (3) Medicaid approved budget;
- (4) Assessment (MAP 351);
- (5) Schedule in fifteen (15) minute units for seven consecutive (7) days; and
- (6) MAP 10.

All required forms must be completed and signed by all responsible parties (consumer or representative, if applicable, and support broker) before an exception request will be reviewed.

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DAIL has five (5) business days to recommend approval or denial of a complete exception request.

Support brokers have ten (10) calendar days to provide any additional documentation that is requested by DAIL. If they fail to do so, DAIL will notify via email, the support broker and their supervisor, that exception request will no longer be reviewed if any additional documentation has not been provided within ten (10) calendar days. At this time, a new exception request will have to be re-submitted.

CONSUMER DIRECTED OPTION Employee Requirements	DAIL-CDO 6.21
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Employee Requirements

A CDO provider serving a consumer in any of the 1915c waiver programs shall meet the following criteria:

- (1) Be selected by the consumer;
- (2) Complete a CDO Employment Application;
- (3) Be eighteen (18) years or age or older;
- (4) Be a citizen of the United States with a valid Social Security number or a valid work permit if not a US citizen;
- (5) Be able to communicate effectively with the consumer, representative, or family;
- (6) Be able to understand and carry out instruction;
- (7) Be able to keep records as required by the consumer;
- (8) Complete a Kentucky CDO Employee/Provider Contract;
- (9) Complete I-9 form (Employment Eligibility Verification);
- (10) Complete W-4 form (Employee's Withholding Allowance Certification);
- (11) Complete K-4 form (Employee's Exemption Certificate);
- (12) Submit to a criminal background check conducted by the Administrative Office of the Courts (AOC);
- (13) Have not pled guilty or been convicted of committing a sex crime or violent crime as defined in KRS 17.165(1) through (3);
- (14) Submit to a nurse aide abuse registry check maintained in accordance with 906 KAR 1:100 and not be found on the registry;
- (15) For ABI, ABI-LTC and SCL waivers only: Submit to a central registry check maintained in accordance with 922 KAR 1:470 and not be found on the registry;
- (16) Complete and verify training on principles of self-determination;
- (17) Complete and verify training on timesheets;
- (18) Complete and verify training on the reporting of abuse, neglect, or exploitation in accordance with KRS 209.030 or 620.30;
- (19) Complete and verify training on person-centered planning;
- (20) Complete and verify training on fraud;
- (21) Complete any additional topics required by the support brokerage agency, DAIL, DMS, or the employer (consumer/representative); and
- (22) Be approved by DAIL.

The above documents must be obtained by the consumer and given to the support broker in order for the hiring process to begin. Any Provider seeking to work for more than one Consumer, regardless of relationship, must complete and submit all

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original paperwork for each Consumer to the Support Broker. The provider shall not begin providing a CDO service until the consumer receives a PA for direct services, employee(s)

have been trained on the above mentioned topics by the consumer and support broker (if support broker is willing) all background checks have come back to the support brokerage agency and results are in compliance with the appropriate KAR.

To check whether an employee is listed on the Nurse Aide Abuse Registry, follow the instructions below:

1. Go to <http://secure.kentucky.gov/kbn/bulkvalidation/basic.aspx>.
2. Type in employee's first and last name (do not use middle initials or names).
3. Search for results.
4. If there are no names listed, print the form.
5. If there are names listed, validate the search.
6. Once search is validated, review the names and check to see if any names are listed on the Office of Inspector General (OIG) Nurse Aide Abuse Registry.
7. If there are names listed, be sure to identify (next to the name or somewhere on form) whether the person listed on registry *is* or *is not* the prospective employee.
8. Print the form.
9. Ensure the date is listed at bottom of form. If no date is listed, write in the date check was run.
10. File in consumer or employee file.

Effective May 1, 2012, all CDO consumers and/or representatives must obtain required background checks as specified per Medicaid Waiver regulations for all potential CDO employees prior to employment. Since background checks are not a Medicaid reimbursable service, the CDO consumer, representative or the potential employee will be responsible for the payment of any required fees for background check processing and documentation. Support Broker Agencies may assist with the processing of background checks; however, any required costs must be paid prior to submission.

While any additional cost to the consumer, representative or employee is regrettable, one of the core principles of CDO is that the consumer is the employer of record. Typically with any employment opportunity the employer or employee is responsible for obtaining required background checks. The Cabinet is not directing who must pay for this background check. This cost could be shared between

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employers, employees, their representatives, or any other entity willing to provide funding for the criminal background check.

The consumer or representative must secure and submit original background check documentation to their designated support broker agency prior to services being initiated by the potential employee. The support broker agency shall verify that the background check documentation meets the CDO employee eligibility requirements. Documentation must be filed in the consumer or employee chart by the support broker agency.

Three (3) ways to obtain a criminal background check are as follows:

1. In person - at 100 Mill Creek Park, Frankfort, KY 40601. Usual timeframe to obtain results is five (5) and ten (10) minutes.
2. Via mail (sent to same address as above). Usual timeframe to obtain results is between two (2) and three (3) weeks.
3. Online (at www.courts.ky.gov). Usual timeframe to receive results is within 24 – 72 hours.

To obtain an individual criminal background check, complete the Criminal Record Report Request Form (RU-004) and submit as indicated above. The cost to obtain a check is \$15.00 via cash (if submitting in person), check or money order made payable to Kentucky State Treasurer, or \$17.00 (by use of credit card) and must be submitted with the RU-004 form.

When the support broker agency obtains the results from the consumer/representative, it is important that support broker verifies that all names listed on the RU-004 form matches the name/names listed on the results.

To obtain a Central Registry Check, follow the instructions below:

1. Employer must complete the form DPP-156.
2. Submit the completed form to the DCBS address on the form. The form may be obtained online (DCBS website, <http://chfs.ky.gov/dcbs>), from a local DCBS office, or from CHFS (Records Management or Division of Childcare).
3. The cost to obtain a check is \$10.00 and must be submitted with the DPP-156 form via check or money order made payable to Kentucky State Treasurer.
4. Results must be sent to the address of the support broker agency with which the consumer is working.
5. Usual timeframe to receive results are within 30 days.

**CONSUMER DIRECTED OPTION
Employee Requirements**

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DAIL-100 Form Instructions

ALL documentation on the DAIL-100 form must be typed. To ensure consistency and accuracy, the support broker shall follow these instructions, as well as the instructions found on the DAIL-100 form.

- (1) **Consumer's Demographic Information.** Enter consumer's full legal name (i.e. last, first, and middle initial), date of birth (DOB), current age, current telephone number, and ten-digit Medical Assistance Identification (MAID) number (as obtained from the assessment).
 - i. If consumer has received Medicaid for less than one month, select new Medicaid member. If consumer has received Medicaid for one month or longer, select existing Medicaid member. Select one only.*
 - ii. If consumer has never received a traditional waiver service before and is choosing CDO, select New Waiver Participant. If consumer has received traditional waiver services in the past or is currently receiving traditional waiver services but now is choosing CDO, select Traditional Waiver Participant Choosing CDO. If consumer has been receiving CDO for ninety (90) days or longer, select Participant Currently Receiving CDO Services. Select one only.*
 - iii. Select which waiver program the consumer is receiving services from.*
 - iv. Enter the current Level of Care (LOC) dates located on the assessment.*

- (2) **Support Brokerage Agency Information.** Enter the name of the Area Agency on Aging and Independent Living (AAAIL) or Community Mental Health Center (CMHC) that is providing support brokerage services, and their Medicaid provider number that pertains to the specific waiver program. Enter the support broker's first and last name, telephone number including extension, and email address.

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- (3) **CDO Exception Request Information.** Enter the date the exception request is submitted (i.e. scanned and emailed) to DAIL, the date that the consumer's CDO enrollment began (as documented on the MAP-2000), and the consumer's initial or current ANNUAL budget amount that was approved by Medicaid. Enter total amount only. Do not enter the amounts for each service. Submit a copy of the Medicaid approved budget with each request packet.
- i. **SB Requested Budget.** Enter the monthly and annual requested budget amount, which should be substantiated by the support spending plan (i.e. page 3) of the plan of care. Omit administrative costs, and just calculate the budget of direct services needed.
- (4) **Exception Consideration Policy.** Exception requests will be considered using the approved exception level policy outlined within the DAIL-100 form and Kentucky Administrative Regulation (KAR). Do not submit an exception request that does not meet exception level and KAR criteria.
- i. **Exception Level I.** For a consumer to meet the level I criteria, all four statements must be true. If at least one statement is not true, an exception request should not be submitted.
- ii. **Exception Level II.** For a consumer to meet the level II criteria at least one of the three statements must be true. Each statement that applies to the catastrophic situation may be checked.

Note: Support brokers must indicate which exception level criteria was met and describe in detail the basis for their determination. Use the exception request summary section to document this information.

- (5) **Consumer's Diagnoses.** List all of the diagnoses provided on the assessment and MAP-10 (which must be signed by a physician, APRN, QMRP or PA). Provide a complete definition and explanation of any diagnoses that might be unfamiliar to non-clinical staff. Submit a copy of the assessment and MAP-10 with the exception packet.

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- (6) **Was An Exception Request Previously Submitted?** Indicate if an exception request was previously submitted to DAIL. If an exception request was previously approved, provide the justification(s) for the exception, date, and annual budget amount authorized by Medicaid. If an exception request was previously denied, provide the justification(s) for the exception, date, and reason(s) for denial.
- (7) **Dates of the Assessment and Plan of Care.** Provide the dates the assessment and plan of care were completed/developed based on needs. The assessment and plan of care must be included in the exception request packet.

Note: Support brokers must develop a support spending plan based on needs regardless of the budget amount given.

- (8) **CDO Service(s) Requested.** For each requested service, enter the CDO billing code, service name/title, number of MONTHLY hours, and negotiated hourly pay rate of the employee(s). This information should be documented on the plan of care, which is to be prepared in cooperation with the consumer/representative, support broker, and other members of the person-centered planning team.

It is imperative that support brokers check for the accuracy of their exception request packets and ensure that their requests do not exceed the traditional Medicaid rates for an appropriate waiver program. Additionally, support brokers must make certain that the requested service(s) and monthly hours are based on the consumer's documented NEEDS, and not his/her wants or desires. All services requested must be supported by the assessment, plan of care, and MAP-10.

- (9) **Weekly Service Schedule.** Develop a weekly service schedule or calendar using the criteria outlined within the DAIL-100 form. Start with the time the consumer wakes, and continue until the time the consumer goes to bed to sleep. DO NOT leave times blank or omit requested CDO services(s) that are scheduled and needed. Times are to be in 15 MINUTE INCREMENTS. This schedule must be typed, initialed by both the support broker and the consumer or representative, and included in the exception request packet.

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- (10) **Justification for CDO Service(s) Requested.** In detail, explain the reason(s) for modifying or adding service(s). Address at a minimum the specific topics outlined within the DAIL-100 form. These responses should reinforce the exception level criteria and the needs of the consumer.
- (11) **Support Broker Exception Request Summary.** Follow the instructions outlined within the DAIL-100 form to complete the summary. Provide more detail than what is written within the plan of care clinical summary. Include whether or not an employee is a family member and his/her relationship to the consumer. Indicate if the consumer receives other non-Medicaid benefits or services, such as the Personal Care Attendant Program, Hart Supported Living Program, Homecare Program, DCBS State Supplementation Services (Personal Care Home, Family Care Home, Caretaker Services), EPSDT, and etc. Include details about the natural support system and what service(s) they provide, or why they are not able or willing to provide the needed service(s).

Note: If CDO services are not requested for seven (7) days per week, the support broker must provide documentation why services are not requested on those days. The weekly CDO service schedule must outline the days that CDO services are requested.

The remainder of the document is reserved for the use of the DAIL CDO Reviewer. Support brokers should not complete this information. The DAIL CDO Reviewer will discuss their preliminary recommendation with the DAIL Commissioner, who will make a final recommendation of approval or denial. The DAIL CDO Reviewer will submit DAIL denied recommendations to support brokers via email and DAIL approved recommendations to Medicaid. After Medicaid makes a final decision, the DAIL CDO Reviewer will contact the support broker via email. DAIL will post any Medicaid authorized exception request budgets on the secured MoveIT site for support brokers. Support brokers may contact the DAIL CDO Reviewer or Branch Manager with any questions or clarification needed.

REMINDER: SCAN AND EMAIL ALL EXCEPTION REQUEST PACKETS

CONSUMER DIRECTED OPTION Timesheet Instructions and Expectations	DAIL-CDO 6.23
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Timesheet Instructions and Expectations

Consumers/representatives and employees shall utilize the standardized timesheet provided by DAIL and DMS. Consumers/representatives and employees must maintain documentation of services or activities performed, as well as hours worked and submit them according to their support brokerage agency and/or financial management agency's written policy. **No modifications to the document are allowed.**

At least one payroll sheet must be used for each employee. Consumer/representatives and employees shall be held responsible for the accurate reporting of time.

Timesheets shall be completed in a clear and legible manner. A correction must be a single line through the mistake, with the initials of the personal making the correction and date. No other correction marks are allowable. Inappropriate corrections shall result in a Corrective Action Plan (CAP), and may result in a delay of processing the timesheet / payment.

All Fiscal Intermediaries must reimburse Consumer Directed Options (CDO) employees/providers for services, designated on the consumer's Plan of Care, provided once presented with a complete, approved timesheet. Per language in KRS 337.010, payment of employees' wages shall be as often as semimonthly and wages or salary shall be paid. No payments for services provided by CDO employee/providers can be denied. Payments for services can be delayed no less than 6 (six) business days and no more than 18 (eighteen) calendar days past pay period once a complete, approved timesheet is received.

Complete the employer/employee timesheet on page one (1) as outlined below:

- (1) Support broker responsibility –
 - Consumer name - type first and last name as indicated on plan of care;
 - Employee name - type first and last name as indicated on plan of care;
 - If applicable, identification (ID) # - type MAID # for consumer, and provider # or SSN # for provider;
 - Pay period - type start and end date of time period;

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- Provider address/zip - type address as indicated on plan of care;
 - Gross total amount for pay period - for each service, list appropriate billing code, hours, pay rates, and total amount; and
 - Signature and date - original signature of support broker and date signed.
- (2) Provider responsibility –
- Date service provided - list the dates of providing approved service(s);
 - Service provided - label approved service(s);
 - Time in/time out - list actual start time and end time with a.m. or p.m.;
 - Total time - list total time a service was provided on each day;
 - Total hours - list total hours provided for each service; and
 - Signature and date - original signature of provider and date signed;
- (3) Consumer/representative responsibility –
- Signature and date - original signature of employer (i.e. consumer or representative) and date signed;

Note: By signing - the consumer/representative/employer and provider certifies that all information is true and correct; and the support broker certifies the authenticity of the signatures, that policies are being upheld, that the plan of care is being followed, and that no overtime or white outs have been documented.

Complete the service documentation on page two (2) as outlined below:

- (1) Support broker responsibility –
- a. Consumer name - list first and last name as indicated on plan of care;
 - b. Provider name - list first and last name as indicated on plan of care; and
 - c. If applicable, identification (ID) # - type MAID # for consumer, and provider # or SSN # for provider;
- (2) Provider responsibility –
- a. For each date of service, document the following –
 - i. A brief description of the activities provided per service definition;
 - ii. Information regarding the health, safety, and welfare of the consumer;
 - iii. Concerns/issues that may have occurred on that date; and

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- iv. Progression, regression, or maintenance of goals listed on the plan of care.

Multiple copies can be produced and attached to one (1) timesheet. Incomplete documentation of services shall result in a CAP, and may result in a delay of processing the timesheet/payment.

Original timesheets must be placed in consumer or provider files.

CONSUMER DIRECTED OPTION Corrective Action Plans (CAP)	DAIL-CDO 6.24
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Corrective Action Plans (CAP)

CAPs may be initiated with a consumer and/or representative when the following occurs:

- (1) It is determined that they are not compliant with CDO guidelines;
- (2) When the consumer/representative present a safety risk to themselves or others; and
- (3) Before terminating or recommending termination of a consumer from CDO.

A CAP must be implemented for any one (1) or more of the four (4) conditions of immediate termination prior to terminating. This is recommended only if it does not present a safety risk for the support broker. This recommendation is so that the support brokerage agency shows due diligence in working with the consumer to correct the problem.

When a CAP is warranted, complete the DAIL standardized Corrective Action Plan form.

The six (6) major components to a CAP include the following:

- (1) **Identify the problem/state the issue** - State who is involved, as well as any applicable dates, times, and places, and action(s) that may have been precursors to the issue at hand.
- (2) **Regulation/Policy violation** - State the relevant regulation and/or policy(ies) that is violated. This can also include agency policy(ies).
- (3) **Agreed upon resolution** - State how any individual(s) are involved, including any supports, if applicable, will work to become in compliance with the issue stated above. This shall include any specified time determined by the support broker, allowing at least 30 days and up to 90 days.
- (4) **Potential consequences** - State what action(s) would be taken should the above stated issue be repeated. This can include either during the stated timeline of the resolution or after the stated timeline.

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- (5) **Prevention** - State how, if applicable, mechanisms and / or ideals could be used to assist in preventing the above issue from being repeated. This may include designating a representative.
- (6) **Signatures** - The consumer/representative, support broker, and any other parties involved shall sign the plan to show acknowledgement and agreement of the terms.

Examples of when a support broker should implement a CAP include, but are not limited to, the following situations:

- (1) When the consumer is unable to maintain providers with the support broker's assistance and they have exhausted all local providing resources.
- (2) When inappropriate corrections are made on provider timesheets and not identified by the consumer prior to forwarding to the support broker.

CAPs must be located in the consumer's file.

Support broker case notes must identify when a CAP is implemented, timeline for the problem to be resolved, and a follow-up at the end of timeline on whether CAP was resolved or termination is recommended.

CONSUMER DIRECTED OPTION Provider Agency Requirements	DAIL-CDO 6.25
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Provider Agency Requirements

(1) OIG Certified Provider Agency

DAIL and DMS have determined that CDO Provider Agencies certified with the Office of Inspector General (OIG) to provide direct care services must have met the minimum employment requirements as outlined in the appropriate waiver KAR.

These provider agencies must provide a copy of the OIG certificate, to be placed in the consumer's file, for all consumers to whom they are providing services. This is to ensure that the provider agency has met all requirements of employment (i.e. background checks, training, citizenship, etc).

The certificate will provide assurances that all provider agency employees have met the minimum CDO employee requirements to provide services.

(2) Provider Agency not certified by OIG

Agencies that are not certified by OIG and providing services for CDO consumers must provide all required employment documentation for individual employees providing services to CDO consumers. This includes the criminal background check, nurse aide abuse registry, and central registry check for the appropriate waiver program. All required information must be provided to the support brokerage agency and placed in the consumer's file.

CONSUMER DIRECTED OPTION Incident Reports (IR)	DAIL-CDO 6.26
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Incident Reports

An incident is an unforeseen or unplanned event or circumstance that occurs out of the ordinary. An incident shall be documented on an Incident Report Form using the revised version dated 7/23/2008. The Incident Report Form can be found at the following website: <http://chfs.ky.gov/nr/rdonlyres/9a84cf6c-bf33-4c5a-ba10-0cbda0ad842f/0/incidentreportrev72320082.pdf>

A question on the IR asks if the consumer is adjudicated. The support broker would check, 'yes' for adjudication if the consumer has been deemed disabled by the court. The support broker would check 'no' for adjudication if the consumer has not been deemed disabled by the court.

Incidents are categorized into classes: Class I, Class II and Class III:

- (1) A **Class I** incident is minor in nature and does not create a serious consequence (nobody was injured, no physical harm or chemical restraints were needed, no police, court, or Adult/Child Protective agency involvement was necessary and incident did not require an investigation).
- (2) A **Class II** incident is serious in nature, involves the use of physical or chemical restraint (MP, SCL, ABI-LTC only), includes a medication error (ABI, ABI-LT only), results in injury to any involved party, requires an investigation by the provider, and may or may not necessitate police or court involvement.
- (3) A **Class III** incident is grave in nature, includes serious injury to any involved party, involve suspected abuse, neglect, or exploitation necessitating Adult or Child Protective agency involvement, may or may not require police or court involvement, includes medication errors that requires a medical intervention, involve a death, and immediate investigation is indicated.

Class I Incidents must:

- Be reported to support broker within 24 hours; and
- Be reported to guardian.

Class II Incidents shall:

- Be reported to the support broker within 24 hours of discovery;

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- Require an investigation which will be initiated and involve the support broker within 24 hours of discovery;
- Support broker to notify guardian within 24 hours of discovery;
- Support broker to report incident to DAIL within 24 hours of discovery; and
- Support broker to send DAIL a complete written report of the incident investigation and follow-up within 10 calendar days of discovery.

Class III Incidents must:

- Have an investigation be initiated immediately upon discovery and involve the support broker;
- Be reported by the support broker within 8 hours;
- Have support broker notify the Department for Community Based Services – Adult Protective Services (APS)/Child Protective Services (CPS) immediately upon discovery, if involving suspected abuse, neglect, or exploitation in accordance with KRS Chapter 209;
- Have support broker notify the guardian within 8 hours of discovery;
- Have support broker notify DAIL in writing within 8 hours of discovery. If incident occurs after 5pm EST on a weekday or occurs on a weekend or holiday, written notification to DAIL shall occur on the following business day; and
- Have support broker send DAIL a complete written report of the incident investigation and follow-up within 7 calendar days of discovery.

All incident reports shall be kept in a centralized file, separate from the consumer’s file.

IRs may warrant a CAP.

Incident reports must be submitted to the following Departments as indicated below:

ABI Waivers:

DAIL (502) 564-7572 (*submit Class II and III only*)
ABI Waiver Branch (502) 564-6568

SCL and MP Waivers:

DAIL (502) 564-7572 (*submit Class II and III only*)
DDID (502) 564-2284

HCB Waivers:

DAIL (502) 564-7572 (*submit Class II and III only*)

CONSUMER DIRECTED OPTION Terminations	DAIL-CDO 6.27
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Terminations

Support Brokers and financial managers shall make every effort to assist the consumer in all aspects of traditional and CDO waiver services for the successful management of services; however, voluntary and involuntary termination from CDO may be necessary due to consumer choice or threat to the health, safety or welfare of consumer.

There are two (2) types of termination:

- **Voluntary:**
 - Requested by the consumer;
 - Support broker to facilitate the completion of the MAP 2000 (page 2) with consumer initialing and dating form;
 - Support broker to forward the completed MAP 2000 to QIO; and
 - If consumer requests transferring back to traditional waiver services, support broker will assist in facilitating the transition.
- **Involuntary:**
 - Consumer is hospitalized sixty (60) days or longer;
 - Consumer goes sixty (60) or more consecutive days without utilizing a direct care service (except for MP and HCB); and
 - Consumer is noncompliant with plan of care.

If a documented history of CAPs is determined unsuccessful, then a consumer can be recommended for termination.

Prior to any other involuntary terminations (besides above mentioned), it is required to implement a CAP.

Support brokerage agency may immediately terminate a consumer from CDO services:

1. If imminent danger to consumer's health, safety and welfare exist (ABI, ABI-LTC, HCB, MP, SCL);
2. If consumer fails to pay patient liability (ABI-LTC, HCB, MP);
3. If consumer's POC indicates he/she requires more hours of service than the program can provide thus jeopardizing the consumer's health, safety, or

CONSUMER DIRECTED OPTION Terminations	DAIL-CDO 6.27
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welfare due to consumer being left alone without a caregiver present (ABI, ABI-LTC, HCB, MP); and

4. If consumer, consumer's caregiver, family or guardian threaten or intimidate a Support Broker or other CDO staff (ABI, ABI-LTC, HCB, MP).

In order to immediately terminate a consumer from CDO, the support broker must complete the MAP 2000 (page 2) and fax to QIO.

Prior to terminating a consumer from CDO, the support broker shall implement a CAP for all concerns leading up to involuntary termination, except in the four (4) conditions where immediate termination is allowed. If consumer fails to adhere to CAP within the timeline specified in the CAP, support broker may proceed with termination.

CONSUMER DIRECTED OPTION Support Broker Monthly Face-to-Face Visits	DAIL-CDO-6.28
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Support Broker Monthly Face-to-Face Visits

Support broker shall conduct a face-to-face visit at least monthly with the consumer and CDO representative, if applicable.

Visit must be conducted in a location outlined in the administrative regulation for the appropriate waiver program.

- **SCL** – monthly face-to-face contact with consumer and representative, if applicable at consumer's home or anywhere in the community;
- **HCB** – (expectation in CDO for SB) monthly face-to-face contact with consumer and representative, if applicable in consumer's home or at ADHC with at least one (1) visit occurring in the consumer's residence every other month;
- **MP** – monthly face-to-face contact with consumer at consumer's home, ADHC or ADT;
- **ABI** – Two (2) face-to-face visits with consumer within one (1) calendar month occurring no more than 14 days apart at a covered service site (ADHC, ADT, SE or home) with one (1) visit quarterly in consumer's home; and
- **ABI-LT** – One (1) face-to-face monthly visit with consumer at a covered service site (ADHC, ADT, SE or home) with at least one (1) visit quarterly at consumer's home.

Expectations of Support Broker during monthly face-to-face visits:

- Monthly Expenditure Report shall be given to the consumer or representative, if applicable;
- Support broker shall review total budget allocated and total hours allocated;
- Support broker shall break down monthly budget and hours utilized;
- Support broker shall break down percentage of annual budget utilized to date;
- Support broker shall discuss with the consumer or representative any health and safety issues, and wellbeing; and
- Support broker shall discuss with the consumer or representative progress toward goals/outcomes identified on the plan of care.

CONSUMER DIRECTED OPTION Support Broker Monthly Face-to-Face Visits	DAIL-CDO-6.28
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Monthly summary case note addressing the face-to-face visit shall include, at a minimum, the following:

- (1) Documentation that the consumer's personal budget was reviewed and discussed;
- (2) Documentation that health and safety issues were discussed with the consumer and representative, if applicable;
- (3) Documentation of consumer's general wellbeing;
- (4) Documentation that progress toward goals/outcomes were identified;
- (5) Support broker's signature and date (month/day/year) located on the monthly summary note; and
- (6) Summary note placed in consumer's file within ten (10) calendar days of face-to-face visit.

Hospitalizations should be documented in case notes including admission date, discharge date, and reason for hospitalization.